STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: _____ B. WING _____	C 11/28/2023

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ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Complaint Investigation: 2399478/IL166665 Facility Reported Incident: FRI of 10/26/23/IL166226	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999		

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S9999	Continued From page 2 that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met evidenced by: Based on observations, interviews, and record reviews, the facility failed to develop and implement effective interventions to prevent or reduce the risk of falling for residents with history of fall and assessed to require extensive assistance for toileting. This affected two of three residents (R6, R5) reviewed for fall prevention interventions. This failure resulted in R6 falling at night while attempting to self-transfer to commode and sustaining a left comminuted and displaced hip fracture requiring surgical intervention. Findings include: 1. On 11/17/23 at 11:25 AM, this surveyor observed R6 lying in bed with eyes closed. R6 had a floor mat on the right side of bed between the bed and wall. The floor mat for the left side of the bed was folded in half and leaning against the wall. On 11/21/23 at 12:07 PM, R6 stated that R6 fell in R6's room on Friday, 10/20/23, around 8:00-9:00 PM. R6 stated that she was going to use her commode and the commode was half on the floor and half on the floor mat. R6 stated that the commode was uneven and she lost her balance and fell. R6 stated that she injured her leg and went to the hospital. R6 stated she broke her knee in 3 different places. R6 stated that she did not ask for help when she went to the commode. R6 stated that she regrets going to the commode and that if she went to the toilet this accident	S9999		

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S9999	Continued From page 3	S9999		

wouldn't have happened. R6 stated that now she can't use the commode and the staff will assist R6 to the bathroom. R6 stated that she has to call for help and she can't do anything without staff assistance.

On 11/22/23 at 10:30 AM, V5 (Restorative Nurse) stated that R6 previously needed only limited assistance with ADLs (activities of daily living). V5 stated that over the past few months R6 has been needing more assistance with ADLs; weakness in both legs has increased. V5 stated that R6 is alert and oriented x 3 but needs reminders to call for toileting assistance. V5 acknowledged that R6 has had three falls at night related to toileting. V5 stated that staff are aware that R6 has a habit of getting up without asking for assistance. V5 stated that staff are aware that R6 needs frequent monitoring and rounding at night; staff round on R6 every two hours during the night. V5 stated that during the night staff should check to see if R6 needs help. V5 stated that staff should not wake R6 up but when round if R6 is awake should ask if she needs help. V5 stated that staff should make sure bedside commode properly placed with all four legs on a hard surface for stability.

R6's medical record notes the following:
On 6/3/23 at midnight, V10 RN (Registered Nurse) was alerted by CNA (Certified Nurse Aide) on duty that R6 was found sitting on the floor next to her bed and assisted her back to her bed, R6 did not utilize call-light bell. V10 found R6 in her bed. R6 stated that she was trying to get out of bed on her own to use the bathroom and fell from her bed.
On 7/5/23 at 1:12 pm, V6 RN noted R6 was found sitting on floor on right side of bed. R6 was observed to have one brief on left ankle and one

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brief on right ankle. R6 stated that R6 was putting on brief and slipped from the bed landing on her buttocks.
On 10/14 10:17 PM, V11 RN noted CNA noted R6 was sitting on the floor at 8.45 PM and called for help. V11 went and saw that R6 was on the floor sitting trying to get up telling V11 that she was fine. On physical examination, R6 was found to have a skin tear on her right elbow and she hit her right cheek and jaw on the commode chair and R6 has a minor cut on her cheek. V11 helped R6 to go to the bed.
On 10/20 at 11:20 PM, V7 LPN (Licensed Practical Nurse) noted: R6 had an unwitnessed fall at around 11:30 PM. R6 was found lying down on her back by CNA after being alerted by R6's roommate. Initially R6 did not complain of pain but a few minutes later stated that she was feeling pain in her left hip. R6 was transported to the hospital and diagnosed with left hip fracture, awaiting surgery.

R6's hospital record, dated 10/21/23, notes R6 was trying to use comode and fell down as the comode was not fully placed properly. R6 fell on left side and currently has 8 out of 10 left hip pain. R6 is not able to lift both legs off the bed due to pain; can attempt on right side but has considerable pain on the left. Left leg is externally roated and shortened. Left hip x-ray showed a comminuted (bone is broken in more than two pieces) and displaced hip fracture. Left hip surgically repaired on 10/21/23. Physical therapist noted R6 with decreased awareness of deficits and assistance required to compensate for deficits.

R6's care plan, dated 12/15/2022, notes R6 is at risk for falls due to muscle weakness, use of assistive device, history of falls, and decreased

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S9999	Continued From page 5 muscle strength. Interventions identified after fall on 10/14 notes floor mats while R6 is in bed and develop toileting schedule for prompted voiding. This facility's management of falls policy, dated 08/2020, notes this facility will develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors include but are not limited to history of fall incidents, incontinence, and behaviors. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. 2. On 11-17-23 at 11:41 AM, R5 said he fell 2 months ago. R5 said staff left his side rails down and he rolled out of bed between the bed and his wheelchair. R5 said the staff is responsible for keeping the siderail up. R5 said he prefers his siderail up for safety. R5 said his bed was in the lowest position and he is able to use the call light. R5 said he makes sure the staff keeps his siderail up when he is sleeping. On 11-21-23 at 11:06 AM, V3 (DON) said R5 had an unwitnessed fall. V3 said R5 said he fell out of his bed. No staff found R5 on the floor, at 5:00 AM, R5 activated his call light to tell Certified Nurse Aide/CNA he rolled out of his bed. R5 was assessed and no pain or injury noted. On 11-21-23 at 2:02 PM, V3 (DON) said R5's care plan was reviewed however it was not modified with new interventions. On 11-17-23 at 12:53 PM, V5 (Fall Nurse) said siderails will protect the resident from falling from bed and assist with bed mobility, turning, and repositioning. V5 said when a resident is sleeping, the bed should be in the lowest position	S9999		

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S9999	Continued From page 6 and siderails up to prevent a fall and for safety. It is everyone's responsibility to ensure the the siderails are up. V5 said R5's fall care plan dated 8-31-23 does not document R5's recent fall or new interventions added. Progress Note dated 9-20-23 documents: Pt had fallen at around 5 am with call light within reach and bed in the lowest position. CNA found pt standing next to bed, stated they had fallen. Pt stated rolled off bed while sleeping. Provided education and did neurological evaluation and post occurrence. Notified DON, R5's Doctor and family member. Pt was sent to hospital for further evaluation. Hospital Record Dated 9-20-23 documents: Chief Complaint: 96 y/o M with h/o HTN, HL, asthma, CKD, CHF, atrial fibrillation, pacemaker, on 2 L nasal cannula at baseline who presents for evaluation status post mechanical fall. Patient is awake alert and oriented and answering questions appropriately. He reports at the nursing home they failed to raise his bed rail and he excellently fell out of bed this morning. He did hit his head but did not lose consciousness. Does report currently that he is feeling a little lightheaded but denies any prodrome of dizziness or lightheadedness prior to the fall. MDM: Patient status post mechanical fall. We will CT head and cervical spine to further evaluate. Diagnosis: Fall, initial encounter. Management of Falls Policy dated 8-2020 documents: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the	S9999		

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S9999	Continued From page 7 resident. Fall Care Plan dated 8-31-23 does not reflect updates of the fall incident dated 9-20-23 nor any newly added fall interventions for the fall of 9-20-23. (A)	S9999		